October 1999

This distribution contains change pages for patch WV*1*7 of the Women's Health 1.0 user manual.

The following documentation change pages should be inserted before these replacement pages:

File Name:	Patch:
WV_1_P3_UM.PDF	WV*1*3
WV_1_P5_UM.PDF	WV*1*5
WV_1_P6_UM.PDF	WV*1*6

Patch WV*1*7 pages:

Replace Pages:	With Pages:
iii-iv	iii-iv
1.1-1.8	1.1-1.10
2.3-2.4	2.3-2.4
2.7-2.20	2.7-2.22
4.3-4.4	4.3-4.4
4.7-4.8	4.7-4.8
4.11-4.16	4.11-4.16
4.19-4.22	4.19-4.22
4.27-4.28	4.27-4.28
4.33-4.38	4.33-4.38
4.41-4.42	4.41-4.42
5.3-5.4	5.3-5.4
5.13-5.14	5.13-5.14
AA.1-AA.6	AA.1-AA.8

Table of Contents

Chapter 1 Implementation and Maintenance

Description

This chapter provides guidelines for implementing the Women's Health application. It is important to complete all of the steps contained in this chapter before assigning menu options to clinical staff.

Women's Health is found in the WV namespace. All routines, templates and options begin with WV. File numbers are in the range of 790 through 794 and are stored in the ^WV global.

Main Features

The Women's Health software is composed of three main modules: Patient Management, Management Reports, and Manager's Functions.

Patient Management is the portion of the software used to manage individual patient care, that is, their procedures, due dates and correspondence. Under the Patient Management menu it is possible to maintain patient data such as the date of the next PAP smear, colposcopy or mammogram, the patient's pregnancy and her EDC (due date), as well as the patient's current PAP regimen. It is also possible to track the patient's individual procedures: the date performed, the provider and clinic, the results or diagnosis, etc. Notifications (letters and phone calls) may also be tracked. A file of form letters has been included in the software, and these letters may be edited and personalized for a clinic's particular needs. Reminder letters can be queued months in advance of a future appointment, then printed and mailed out shortly before the tentative appointment.

Management Reports is the portion of the software used to print epidemiological reports such as the number of women who received a mammogram for the selected time period, or the number of patients having abnormal PAP results during a selected time period. Under the Management Reports menu it is possible to produce lists of patients who are past their due dates for follow-up procedures. It is also possible to store program statistics by date for later comparison of program trends and progress.

Manager's Functions is that portion of the software that provides the ADPAC with a set of utilities for configuring the software to the specific needs of the site. It also provides utilities for other program needs, such as customizing tables, making special edits to patient data (e.g., pregnancy log, PAP regimen log), printing notification letters, running error reports, and documenting laboratory results. By using the File Maintenance options under the Manager's Functions menu, it is possible to maintain site specific parameters such as the text of form letters, the types of notifications and their synonyms, how and when letters get printed, and several defaults relating to dates.

Patients, Procedures, and Notifications

There are primarily three distinct data sets within the WH application and they can be categorized as patient, procedure, and notification related.

Patients refer to the women in the program register. Data stored for each patient includes demographic data, the patient's case manager, the current or next cervical and breast treatment need and its due date, the patient's PAP regimen along with the date it began, and other data. This type of data is referred to as the patient's case data.

Procedures refer to any of the diagnostic and therapeutic tests, exams, or other interventions tracked by the software. The table of procedure types includes PAP smear, colposcopy, mammogram, LEEP, cone biopsy, ECC, and others. The results or diagnosis associated with the gynecologic procedures are chosen from a table of Bethesda-consistent terminology. Mammogram results use the American College of Radiology (ACR) terminology.

Notifications refer to any type of communication or correspondence with the patient, such as first, second and third letters, certified letters, phone calls, messages left, etc. Notifications, which take the form of letters, fall into two categories: results letters and reminder letters. Result letters inform the patient of the findings of a recent procedure and are queued to print immediately. Reminder letters inform the patient of the need to schedule her next appointment and are queued to print at some time several weeks or months in the future.

Selected reports that look at the due dates of patients' treatment needs (using both the procedure and notification data sets) provide a comprehensive mechanism for guarding against losing patients to follow-up.

Case Managers and the Program Manager

Every patient that is entered into the Women's Health database (or 'register') is assigned a case manager. A **case manager** is a user of Women's Health (a registered nurse, LPN, nurse practitioner, or a women veterans health coordinator) who is responsible for managing and tracking a woman's health care needs. This includes treatment planning, tracking of procedures, editing patient data, selecting appropriate letters, scanning for delinquent follow-up care, and more. A small clinic using Women's Health may have only one case manager. Larger clinics and hospitals may have several. In some cases, the tasks associated with the software may be assigned to clerical personnel under the supervision of a licensed care provider.

The **program manager or ADPAC** is the person chiefly responsible for the setup and operation of the Women's Health package at a given site. This person works with the IRM Service on the technical aspects of the software and performs maintenance tasks that require a more detailed understanding of the software than is required of case managers. At small sites, the program manager may also be the only case manager.

The Basic Patient Management Loop

The function of the Women's Health software is best understood in terms of the Basic Patient Management Loop (please refer to the flowchart in this section).

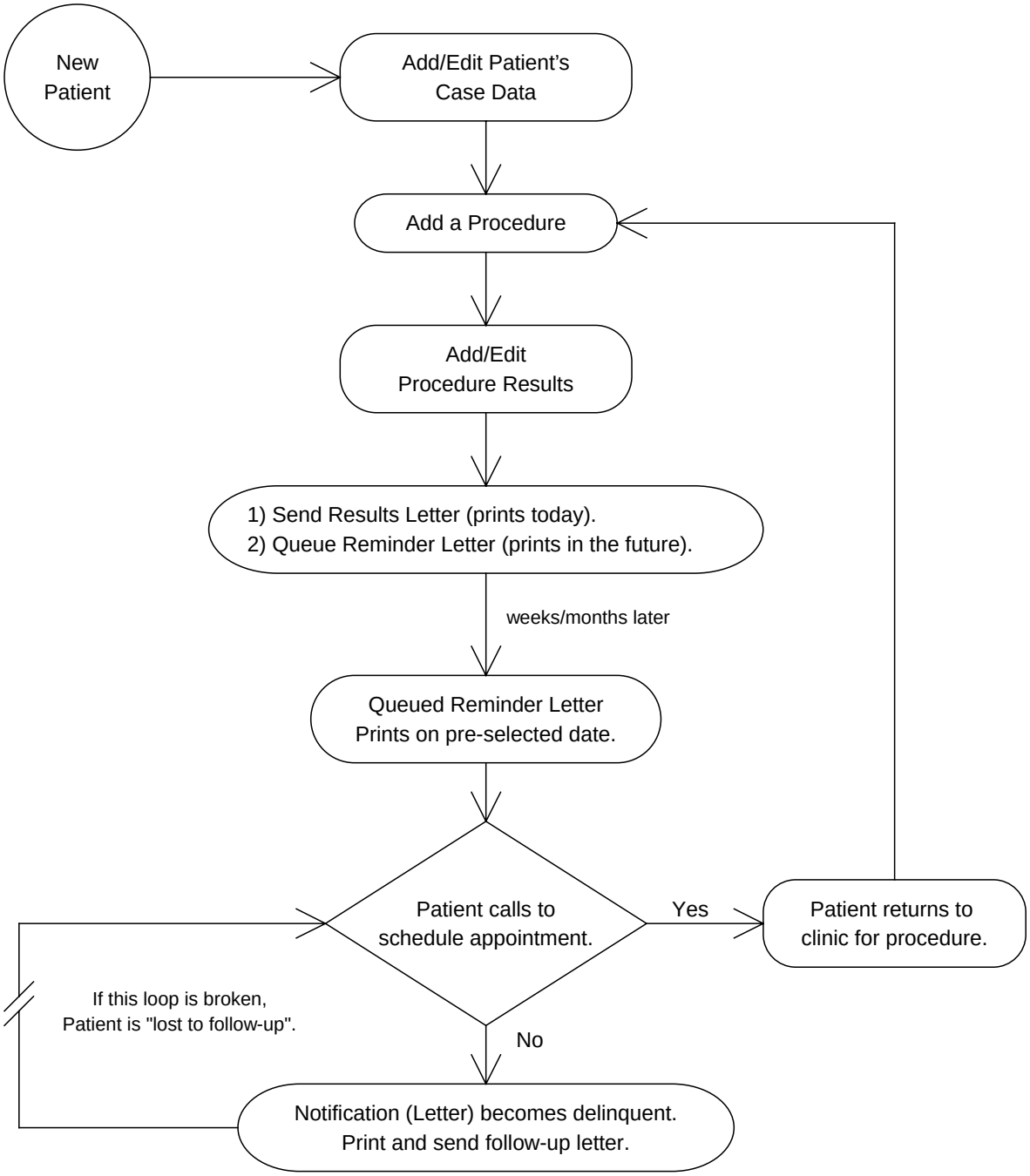
The loop is a sequence of events that occur over and over again during a patient's health care cycle.

This software uses the concept of procedures and notifications being open and closed. Procedures and notifications will become delinquent if they are not closed by the 'Complete by (Date)' field found in the notification and procedure screens. If a procedure or notification is not closed by its due date, this will be an indicator that the patient may be 'lost' to follow-up. Generally, a procedure is closed when the results or diagnosis for that procedure are entered. A notification is closed either at the time it is printed (as in the case of a results letter) or when the patient returns for her next appointment (as in the case of a reminder letter).

An example of the Basic Patient Management Loop would be the following: A new patient arrives at the clinic for care. The patient's case data (PAP and MAM treatment needs, EDC, etc.) are entered into the Women's Health program. A procedure is performed (such as a PAP smear). The procedure is entered into the computer, an accession number is assigned to the procedure, and the specimen is sent to a lab for diagnosis. After a period of days, results are returned from a lab and entered for the procedure and this procedure is then closed. At that time, one and possibly two separate notification letters are selected from the Purpose of Notification file. The first letter, a results letter, informs the patient of the results of the procedure. This letter is printed immediately. The second letter, a reminder letter, will advise the patient to call the clinic in order to schedule her next appointment. This second letter is queued to print one year later (assuming the PAP was normal). Twelve months later, in response to the reminder letter, the patient calls to schedule her next appointment. When she returns to the clinic for her next procedure, the Patient Management Loop begins again: procedure... results...results letter & reminder letter...call for an appointment...procedure.

When the patient returns for a procedure, it is important to close the reminder letter that prompted her appointment; otherwise, the reminder letter will be left open and begin to show up as delinquent on the past due reports.

Basic Patient Management Loop



As noted earlier, the reports that look for the due dates of patients' treatment needs (for procedures, and notifications) provide a comprehensive mechanism for guarding against losing patients to follow-up. The three sets of 'due dates' are as follows:

1) Treatment Need Due Date
Stored as part of each patient's case data are breast treatment needs and gynecologic treatment needs. These needs are chosen from a table and given a due date, such as, 'Routine PAP (by 7/1/95)'. The Women's Health software offers a report that will display/print all of the patients with treatment needs past due.

2) Procedure Complete by Date
A 'Complete by Date' is stored as part of each procedure a patient receives. When a procedure is first entered, it receives a status of 'Open'. When the results of the procedure are returned and entered, the status is generally changed to 'Closed'. If a procedure's status remains 'Open' after its 'Complete by Date', the procedure will begin to display on reports that look for procedures that are past due.

3) Notification Complete by Date
A 'Complete by Date' is stored as part of each notification a patient receives. When a notification is first entered, it receives a status of 'Open'. If the notification is a result letter (to be printed immediately) or a phone call, it is generally given an outcome and a status of 'Closed'. If the notification is a reminder letter, its status is left 'Open' until the patient's next procedure is entered. If a notification's status remains 'Open' after its 'Complete by Date', the notification will begin to display on reports that look for notifications that are past due.

Summary

In summary, Women's Health is largely a patient management tool for tracking the breast and gynecologic treatment needs of women, the procedures they receive, and the communications between healthcare staff and women regarding their treatment and follow-up. The software also provides some program-wide epidemiological reports which are of use to clinicians and program administrators.

Installation of Software:

This is the first version of the V*IST*A Women's Health package. Some VA facilities are running the Indian Health Service Women's Health software (namespace is BW, file range is 9002086-9002086.93). This installation will copy the IHS data into the V*IST*A Women's Health files. It will not change the IHS database and will remain as a legacy database until otherwise determined by the ADPAC and the women veterans coordinator.

1. Setting up the software environment.

Information Resource Management Services staff should install the software using the Installation Guide in a test environment prior to installing the software in the production (VAH) account. The following V*IST*A packages should reside in the environment where the Women's Health application is to be installed:

a. VA FileMan V. 21 or greater,
b. Kernel V. 8.0 or greater,
c. Kernel Toolkit V. 7.3 or greater,
d. PIMS V. 5.3 or greater,
e. Radiology/Nuclear Medicine V. 5.0 or greater (optional),
f. MailMan V. 7.1 or greater.

If Radiology/Nuclear Medicine V. 5.0 and patch RA*5.0*2 are installed patient mammograms can be automatically entered into the Women's Health database.

Data entered into the test environment CANNOT be transferred into the production environment. It is recommended that a limited amount of data be entered into the test directory in order for the user to become familiar with the application and to establish an acceptable training data base.

2. Editing site configurable files.

a. The WV EDIT SITE PARAMETERS option edits the WV SITE PARAMETER (#790.02) file.

b. The WV ADD/EDIT REFERRAL SOURCE option edits the WV REFERRAL SOURCE (#790.07) file.

c. The WV EDIT DIAG TRANSLATION option edits the WV DIAGNOSTIC CODE TRANSLATION (#790.32) file.

d. The WV ADD/EDIT NOT PURPOSE&LETTER option edits the WV NOTIFICATION PURPOSE (#790.404) file.

e. The WV ADD/EDIT NOTIF OUTCOME option edits the WV NOTIFICATION OUTCOME (#790.405) file.

f. The WV ADD/EDIT CASE MANAGERS option edits the WV CASE MANAGER (#790.01) file.

Review the above populated site configurable files. The options, which allow the application coordinator to edit the file's data, are all located in the File Maintenance Menu.

3. Automatically loading files.

At this time, the WV Patient (#790) file can be preloaded with the names of women patients from the Patient (#2) file. This may be done using the Automatically Load Patients option. The mammogram reports from the Radiology/Nuclear Medicine package may also be automatically loaded into the Women's Health package by using the option Import Radiology/NM Exams. For further information on these options, refer to Chapter 2.

4. Queueing TaskMan jobs.

There are no options that need to be queued to run.

5. Accessing menus.

There are no security keys in this application.

6. Assigning menus.

The Women's Health Menu [WVMENU] should be assigned to the ADPAC and the individual having primary responsibility for managing and editing data in this tracking package.

The Patient Management [WV MENU-PATIENT MANAGEMENT] and Management Reports [WV MENU-MANAGEMENT REPORTS] should be assigned to all women's health coordinators and case managers who have not been assigned the Women's Health Menu option. These two options may also be assigned to appropriate clinicians and women's health clinical directors as required.

The Lab Data Entry Menu [WV MENU-LAB DATA ENTRY] should be assigned to laboratory personnel who may be assigned to enter cytology reports into the WH database.

7. Printer issues.

There are no special printer issues.

8. Resource Requirements.

The size of the table files that come with the package are insignificant. Data storage for the package is very roughly 2 megabytes per 1000 patients per year.

WV ADD/EDIT NOT PURPOSE&LETTER

Add/Edit a Notification Purpose & Letter

While notifications may be phone calls or conversations, most notifications will be letters and most of the customizable parameters relate to notifications in the form of letters.

This option allows the ADPAC to add or edit purposes of notification, for example, 'PAP Result Normal' or 'PAP, Annual Due'. Each purpose of notification can have its own form letter, for example, the form letter for 'PAP Result Normal' would include a body of text informing the patient that the results of her recent PAP test were normal. When printed, the form letter automatically includes the patient's name and address information. The position of the name and address can be adjusted in order to have that information appear in the window of a windowed envelope.

The patient's name, address, and SSN will appear automatically within the letter at the places demarcated by the vertical bars "||" (e.g., |SSN|) when the letter is printed. This information is obtained from the WV PATIENT file (#790). If you do not wish to have a certain piece of information displayed in the letter, you should edit the text of the letter and remove that field name (e.g., SSN) and the vertical bars that surround it.

Other information that appears in the letter is the clinic name and address. This information is typed within quotes. You should edit the text between the quotes to display the correct clinic name and address (Note: Leave the quotes). If you plan on printing your letters on paper that contains a letterhead you will want to remove altogether the lines containing the clinic name and address.

The field |NOWRAP| should be left as is. This permits the text of the letter to be printed as it appears on the terminal screen. Other fields may be deleted if not desired. For example, |TODAY| and |NOW| will print out the current date and date/time respectively. Future appointments may be included to print in a notification letter by typing the text "|APPOINTMENTS|" (without the quotes) in the text of the letter.

Because of the specific syntax of the fields and the possibility of corrupting them during edits, a recovery utility has been provided. The program to edit a purpose of notification always asks first if you wish to replace the existing form letter with a 'generic sample letter'. Answering 'Yes' to that question will replace the existing form with a generic sample letter, which includes all of the original fields in their proper syntax.

Once the purpose has been selected and the generic letter question answered,
the 'Edit Notification Purpose & Letter' screen appears. Notification purpose data is stored in the WV Notification Purpose (#790.404) file.

Field Descriptions:

Purpose of Notification:
This field contains the reason for the notification (e.g., the results of a test, reminder to schedule a procedure). This should be brief but descriptive enough to identify it uniquely. NOTE: This field cannot be changed because previous notifications from this purpose would become inaccurate. If the Purpose field is incorrect, make this purpose 'Inactive' (see next field), and then create a new purpose of notification with the correct purpose name.

Active:
This field describes whether or not the purpose of notification may be selected. 'Yes' means the purpose may be selected, 'No' means the purpose may not be selected. This is to eliminate the clutter of unused notifications.

Synonym:
This field stores an abbreviation or short synonym for the notification type. For example, 'LF' for 'Letter, First'.

Priority:
This field associates a priority with the notification. The priority choices are: urgent, ASAP, and routine. These priorities are used within the Browse Notifications options to print a list of notifications by priority.

Form Letter:
This field stores the text of the form letter for this purpose of notification. NOTE: To navigate to this field you must place the cursor at the Priority field and then press the TAB key, then RETURN.

Result or Reminder:
This field contains a code (1 = Result, 2 = Reminder), used to determine a print date for the letter. A notification identified as a result is queued to print immediately and a reminder is queued to print on a future date.

Associate with BR/CX:
This field has a 2-fold purpose. It identifies that the notification letter is associated with cervical or breast treatment needs, and also determines a default print date based on the treatment need type. The value of this field is a set of codes (BR for breast Tx need, CX for cervical Tx need). If a clinician does not want to automatically queue a letter to print, the field may be left blank.

WV ADD/EDIT NOTIF OUTCOME

Add/Edit Notification Outcomes

Each notification, whether it is a letter, phone call, or other notification topic, may be given an 'Outcome'. Outcomes such as 'Declined Tx' and 'Scheduled appt for PAP' come pre-loaded with the software. Using this option, it is possible to add other, user-defined outcomes such as 'Referred to County Hospital'.

It is also possible to make an outcome 'Inactive' if you do not use it and do not wish to have it display in the list of available outcome choices. Notification outcome data is stored in the WV Notification Outcome (#790.405) file.

Field Descriptions:

Outcome:
This field contains the terms describing a notification outcome. An outcome may be a goal or an event (e.g., PAP normal letter sent, provider consult, CBE refused, scheduled appt for MAM).

Active:
This field contains a set of codes (1 = Yes, 0 = No) used to display or hide an entry in a selection list. If the field is active and contains a '1' or yes, users of this package can select the entry.

WV EDIT SITE PARAMETERS

Edit Site Parameters

The Edit Site Parameters option allows the ADPAC to edit several parameters specific to the clinic or hospital where the software is being used. There are 5 pages (or screens) of parameters. After selecting a site (or facility), the screen for page 1 appears. Site parameter data is stored in the WV Site Parameter (#790.02) file.

Field Descriptions:

Site/Facility Name:
This is the name of the facility, division, and/or community based outpatient clinic requiring separate site parameters. If all divisions are using the same site parameters, then enter the name of the primary or lead facility.

Default Case Manager:
This is the name of the case manager or the individual that will be used to initially seed the patient's record. Although the patient's care management can be transferred to another individual, this name is used as the default to deter loss of this patient's treatment needs within the facility and database. Pointer to the WV Case Manager (790.01) file.

Ask Case Manager:
This field is used to display or hide a question asking users if they want to select a particular case manager within the report option, Browse Patients With Needs Past Due. If there is only one case manager at the facility(s), the answer should be no.

Autoqueue Normal PAP Letters:
This field stores a code (0 = No, 1 = Yes) that displays or hides the prompt: "QUEUE a PAP Result Normal letter to be sent to this patient?". This question displays after the user exits either Add a NEW Procedure or Edit a Procedure option and after the results of a PAP smear procedure have been entered into the patient's record. The results/diagnosis must be considered normal.

PAP Result Normal Letter:
This field stores the name of the PAP letter that is printed when the user answers, Yes, to the prompt: "QUEUE a PAP Result Normal letter to be sent to this patient?" after the procedures results have been entered into a patient's record.

Autoqueue Normal MAM Letters:
This field stores a code (0 = No, 1 = Yes) that displays or hides the prompt: "QUEUE a MAM Result Normal letter to be sent to this patient?". This question displays after the user exits either Add a NEW Procedure or Edit a Procedure option and after the results of a mammogram procedure have been entered into the patient's record. The results/diagnosis must be considered normal.

MAM Result Normal Letter:
This field stores the name of the MAM letter that is printed when the user answers, YES, to the prompt: "QUEUE a MAM Result Normal letter to be sent to this patient?" after the procedures results have been entered into a patient's record.

Default #days to print Letters:
Allows the ADPAC to set the default number of days each type of procedure is allowed to remain open before being listed as delinquent. For example, the default for PAPs may be 30 days, but for colposcopies only 14 days, and mammograms only 5 days.

Import Mammograms from Radiology:
This field is used to automatically import and store mammography reports, from the Radiology/Nuclear Medicine package, in the Women's Health database.
NOTE: The Radiology/Nuclear Medicine patch RA*5.0*2 must be installed to use this functionality.

Status Given to Imported Mammograms:
This field automatically stores a default status (O = Open; C = Closed) in the procedure edit screens when mammography reports are imported from the Radiology/Nuclear Medicine application.

Import Test from Laboratory:
This field indicates whether or not to automatically import lab test data from the Laboratory package, into the Women's Health database.
NOTE: The Lab patch LR*5.2*231 must be installed to use this functionality.

After answering the page 2 site parameters, the cursor will drop to the Command Line. Selecting a 'N' (for Next page) at the command prompt will display page 3. Pages 3, 4 and 5 all concern setting the parameters for each of the 27 procedure types.

Procedure Type:
This is not an editable field. It simply lists all of the procedure types that are available for tracking in the Women's Health package.

Active:
If users should NOT be allowed to select a specific procedure type when entering new procedures at this site, then enter 'No' to make it 'Inactive' or unselectable. Enter 'Yes' to make the procedure type 'Active'.

Days Delinquent:
Enter the default number of days that a specific procedure will be allowed to remain ‘Open’ before being marked as ‘Delinquent’.

Pages 4 and 5 of the ‘Edit Site Parameters’ screen are similar to page 3 and permit the configuration of the remaining procedure types.

WV ADD/EDIT CASE MANAGERS

Add/Edit Case Managers

The Add/Edit Case Managers option allows case managers to be selected from the New Person (#200) file. If a person you wish to add as a case manager cannot be selected, contact your site manager. Under this option a case manager may also be inactivated by entering a date at the 'Date Inactivated: ' prompt. A case manager who has been inactivated cannot be assigned to patients because the person does not appear in the selection list in the Edit/Print Patient Case Data option. Case manager data is stored in the WV Case Manager (#790.01) file.

Field Descriptions:

Case Manager:
This field contains the name of a WH case manager assigned to manage women's health needs.

Date Inactivated:
This date field is used to indicate when a person is no longer recognized as a case manager. A future date may be entered here. The case manager remains as an active selection until the date in the field is in the past.

WV TRANSFER CASE MANAGER

Transfer a Case Manager's Patients

The purpose of this utility is to aid in the transfer of a case manager's patients to another case manager, (e.g., when there is a turnover in staff). The program will ask you for the name of the old case manager and then prompt the user to enter the name of a new case manager. All patients who were previously assigned to the old case manager will be reassigned to the new case manager.

If the new case manager you are looking for cannot be selected, the person might have to be added to the file of case managers or have their inactive status changed through the Add/Edit Case Managers option. Case manager data is stored in the WV Case Manager (#790.01) file.

Field Descriptions:

Old Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient.

New Case Manager:
This field contains the name of a person who will be managing the women's health care needs of this patient.

WV AUTOLOAD PATIENTS

Automatically Load Patients

This utility examines the main patient database (File #2) for women veterans seen at a facility within a selected date range, who are over a selected age, and adds them to the Women's Health database.

Women already in the Women's Health database will not be added twice. Women who are deceased will not be added. Women who are veterans or have an eligibility code selected by the user will be added. Women added to the Women's Health database will be given breast and gynecologic treatment needs of 'Undetermined', with no due dates.

This utility may be run at any time, and as often as desired. It may be useful to run it on a monthly basis in order to pick up new women who were added to the main patient database since this option was last run. NOTE: New patients are NOT added to the database without running the option.

Before the program begins, you will be prompted for an age below which patients should not be added, a start date of patient activity, an end date of patient activity, selected eligibility codes to include other patients, and a device. Patients not having a visit or admission between the start and end dates of patient activity will not be added to the file. These dates can be no more than 3 years prior to today's date. The name, SSN, and date of birth for each patient added to the Women's Health database will be displayed on the device. This device may be a printer, or you may simply display the data on your screen. If the device you select is a printer, it may be preferable to 'queue' the job, in order to free up your terminal. See your computer site manager for assistance with queuing jobs.

WARNING: The first time this utility is run, it may add several thousand patients to the Women's Health database. It may take several minutes or even hours to run, depending on the size of the database and speed of the computer. Subsequent runs should be much quicker. You may type '^' at anytime to quit before the program begins.

Report Description:

Name:
This field contains the name of the patient.

SSN:
This field contains the social security number of the patient.

Date of Birth:
This field contains the date of birth for the patient.

Status:
This field contains the status of Added or Failed. Added means the patient was successfully added to File 790, failed means the patient was not successfully added to File 790.

WV IMPORT RAD/NM EXAMS

Import Radiology/NM Exams

This option searches the Radiology/Nuclear Medicine database for all WH patients who had a mammogram or breast/pelvic/vaginal ultrasound exam (CPT codes are 76090, 76091, 76092, 76645, 76830 and 76856) during the date range you select. These procedures and patients will be added to the WH database if not already there.

The job is queued as a background task so as to free up your terminal to do other work. You will receive a mail message when the job is done. The mail message will contain a count of the number of procedures and patients added.

This option asks you to select a start date, end date, the status of the procedures to be added to the WV Procedure (#790.1) file, and whether or not non-veteran patients will be included. Since these are past (old) procedures, you will probably want to mark them as 'Closed'.

NOTE: Please read the Edit Diagnostic Code Translation File option description before running this option.

The following information is included by this option.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

MAM Unilateral: Left or Right:
This field indicates whether this unilateral mammogram is left or right.

Health Care Facility:
This field identifies the name of the health care facility where this procedure was performed.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed.

Date of Procedure:
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Status:
This field contains the status (set of codes: O = Open, C = Closed). The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

WV PRINT RES/DIAG FILE

Print Results/Diagnosis File

For each procedure type in women's health, only certain results or diagnoses may be selected. The Print Results/Diagnosis File option lists in a tabular form all of the procedure types and their corresponding results/diagnoses. The report includes a listing of results by priority as well. These results/diagnoses correspond with the Bethesda Classification system for PAP smears and the American College of Radiology for mammograms. Results/diagnosis data is stored in the WV Results/Diagnosis (#790.31) file.

Report Description:

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Priority:
This field stores an arbitrary number used to prioritize the results or diagnosis term. The range is from 1-90 with 90 being defined as normal or no results, and 1 being the highest priority.

Normal:
This field tells whether the results of the procedure were normal or abnormal. This information is used in autoqueueing normal result letters.

WV EDIT RES/DIAG SYNONYMS

Edit Synonyms for Results/Diagnoses

You may enter a synonym for each procedure type result/diagnosis. The synonym will allow the result/diagnosis to be called up by typing only a few unique characters. Synonyms should be unique and less than 6 characters. For example, 'C1' might be used for CIN I/mild dysplasia; 'C2' for CIN II/moderate dysplasia; 'C3' for CIN III/severe dysplasia, and so on. Each procedure type diagnosis or result may have up to two synonyms. Results/diagnosis data is stored in the WV Results/Diagnosis (#790.31) file.

Field Descriptions:

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Synonym 1:
This field contains a 1-9 character long abbreviation for the result/diagnosis. A facility may add/edit/delete a synonym to suit its needs.

Synonym 2:
This field contains an additional 1-9 character long abbreviation for the result/diagnosis. A facility may add/edit/delete a synonym to suit its needs.

WV PRINT RES/DIAG SYNONYMS

Print Synonyms for Results/Diagnoses

The Print Synonyms for Results/Diagnosis File option lists in tabular form all of the procedure type synonyms and their corresponding results/diagnoses.

Report Description:

Synonym 1:
This field contains a 1-9 character long abbreviation for the result/diagnosis. A facility may add/edit/delete a synonym to suit its needs.

Synonym 2:
This field contains an additional 1-9 character long abbreviation for the result/diagnosis. A facility may add/edit/delete a synonym to suit its needs.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

WV EDIT DIAG TRANSLATION

Edit Diagnostic Code Translation File

When mammograms are imported from the Radiology/Nuclear Medicine package, the diagnoses they are given in the Radiology/Nuclear Medicine package must be matched with the corresponding diagnoses in the Women's Health package. This option allows you to correctly match the diagnoses between the two packages. The first prompt allows you to select a Women's Health diagnosis; the second prompt allows you to select the corresponding radiology diagnostic code. Diagnostic code translation data is stored in the WV Diagnostic Code Translation (#790.32) file.

Field Descriptions:

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Women's Health Diagnosis:
This field contains women's health results/diagnosis terms relating to radiology procedures. Pointer to the WV Results/Diagnosis (#790.31) file.

Radiology Diagnostic Code:
This field contains the Radiology Diagnostic Code associated with a women's health results/diagnosis. Pointer to the Diagnostic Codes (#78.3) file.

WV PRINT DIAG TRANSLATION

Print Diagnostic Code Translation File

The Print Diagnostic Code Translation File option lists all of the Women's Health mammogram diagnoses followed by the corresponding radiology diagnostic codes. Diagnostic code translation data is stored in the WV Diagnostic Code Translation (#790.32) file.

Report Description:

Women's Health:
This field contains women's health results/diagnosis terms relating to radiology procedures. Pointer to the WV Results/Diagnosis (#790.31) file.

Radiology:
This field contains the Radiology Diagnostic Code associated with a women's health results/diagnosis. Pointer to the Diagnostic Codes (#78.3) file.

WV ADD/EDIT REFERRAL SOURCE

Add/Edit to Referral Source File

This option allows the user to add or edit referral sources and determine whether they are active or inactive. Referral source data is stored in the WV Referral Source (#790.07) file.

Field Descriptions:

Referral Source Name:
This field contains a referral source used to describe how the patient was referred to the Women's Health Program. The source can be a clinic, a special event (e.g., health fair), newspaper advertisement, or individual (such as a primary provider, self, other patient).

Status:
This field stores a set of codes (1 = Active, 0 = Inactive) used to display or hide an entry in a selection list. If the field is active, users of this package can select the entry.

Date Inactive:
This field contains the date on which this patient's record became inactive. ANY date (past, present or future) will cause this patient's data to be excluded from all reports that assess treatment needs (i.e., Snapshot of the Program Today report and Browse Patients with Needs Past Due).

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Tx Due Date:
This field contains the date by which the breast Tx procedure should be completed.

Breast Tx Facility:
The name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Tx Due Date:
This field contains the date when this gynecologic procedure or treatment should be completed.

Cervical Tx Facility:
The name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

PAP Regimen:
This field stores the current PAP regimen for the patient. The regimen appears in an abbreviated form so that it can be listed on several screens where there is limited space. The following abbreviations apply:

symbol	meaning
P	PAP
C	colposcopy
wk	week
m	month
y	year
q	every
pp	postpartum
x2	times 2
x3	times 3
ga	gestation

The abbreviations read much like a prescription. For example, 'Pq6mx2, Pqy' stands for 'PAP every 6 months times 2, then PAP every year (annually)'. Another example, 'P6wkpp, C8-12wkpp' stands for 'PAP at 6 weeks postpartum, then colposcopy 8 to 12 weeks postpartum'.

PAP Regimen Start Date:
This field stores a date on which the patient began or will begin her current PAP regimen.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Family Hx of Breast CA:
This field identifies if the patient's relatives have had breast cancer. The information may be selected from a set of codes to indicate no family history, a 2nd degree relative (cousin, aunt, grandmother), a 1st degree relative (mother OR sister), multiple 1st degree relatives (mother AND sister), personal history, or unknown.

Notes (WP):
This is a word processing field that stores additional information about the patient and her health care needs.

Currently Pregnant:
This field contains information on the pregnancy status of the patient. The status is a set of codes: 1 = Yes if this patient is currently pregnant, 0 = No, if not. When the pregnancy status is unknown, the field is blank.

EDC:
This field stores the patient's delivery date or estimated date of confinement (EDC).

DES Daughter:
This field indicates if this patient's mother took diethylstilbestrol (DES) when she was pregnant with this patient. Choices are yes, no, and unknown.

Date of 1st Encounter:
This field contains the date of the patient's first clinic visit. Although a date is automatically stuffed when the Automatically Load Patients [WV AUTOLOAD PATIENTS] option is run, the information can be edited through the Edit/Print Patient Case Data option.

Referral Source:
This field stores information on who referred the patient or how the patient found out about the women's health care services at the facility. This field points to entries in the WV Referral Source (#790.07) file. Additional choices may be added by the facility via the option Add/Edit to Referral Source File.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Primary Provider:
This field contains the name of the primary provider who is responsible for the women's health care needs of this patient.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Family Hx of Breast CA:
This field identifies if the patient's relatives have had breast cancer. The information may be selected from a set of codes to indicate no family history, a 2nd degree relative (cousin, aunt, grandmother), a 1st degree relative (mother OR sister), multiple 1st degree relatives (mother AND sister), personal history, or unknown.

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date:
This field contains the date the procedure was performed.

Procedure:
This field displays the abbreviation of the procedure (type) performed on the patient. Pointer to the WV Procedure (#790.1) file.

Results/Diagnosis:
This field displays the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

The following fields only appear on the detailed report:

PAP Regimen Change:
This is the beginning date of change and the name of the new regimen.

Pregnancy Status:
This field contains information on the pregnancy status of the patient. The status is a set of codes: 1 = Yes if this patient is currently pregnant, 0 = No, if not. When the pregnancy status is unknown, the field is blank.

Notifications:
This includes the procedure accession number and name associated with the notification, notification outcome, status, purpose and type.

Procedures:
This field includes the Women's Health procedure accession number.

Currently enrolled in:
This field contains any insurance programs the patient is currently enrolled in.

Future Appointments:
This field contains a list of any future appointments the patient may have.

Remarks:
This field contains any short comments the user may wish to enter about this patient.

WV BROWSE NEEDS PAST DUE

Browse Patients With Needs Past Due

This option allows you to search for and browse through patients whose treatment needs are past due. The five questions that are asked prior to the display allow you to specify the needs, dates, case managers, order of display, and device for the display.

NOTE: It may be useful to select a date at some time in the future, for example, two weeks ahead, in order to anticipate which patients will become delinquent and to act on those cases ahead of time.

If the device selected is 'Home' (to the screen), a column of numbers will appear to the left of the chart numbers.

A patient will not be processed if there is any value (past, present, or future) in the Date Inactive field on the Edit/Print Patient Case Data option screen. Patient needs past due data is stored in the WV Patient (#790) file.

NOTE: When the option is run it checks the Patient (#2) file for a date of death. If there is a date of death, it will be entered as the inactive date in the Women's Health database.

Report Description:

SSN:
This field contains the social security number of the patient.

Patient:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

Case Manager:
This field contains the name of a person who is currently managing the women's health care needs of this patient.

Treatment Need and Due by Date:
This field contains the name of the current or next procedure or treatment need scheduled for this patient, including the due by date.

Primary Care Provider:
This field contains the name of the primary provider who is responsible for the women's health care needs of this patient.

WV SAVE LAB TEST

Save Lab Test as Procedure

This option is used to save lab tests as procedure entries in the Women's Health package. Lab tests for cytology and surgical pathology are passed to the Women's Health package from the Lab package and stored in the WV Lab Tests (#790.08) file. A mail message is sent to the patient's case manager stating a lab test has been released to the Women's Health package. This option allows the user to first view the lab tests in an uneditable screen, then dispose of the lab tests either by 1) adding the lab test data into a Women's Health package procedure, 2) deleting the lab test from the WV Lab Tests file (i.e., don't convert it into a Women's Health procedure), or 3) ignore the lab test for the time being. The lab test can be looked up by requesting provider, lab accession, patient name or SSN, or date of test.

If the user chooses to add the lab test to the Women's Health package, the user is first asked to select a WH procedure type, to associate with the lab test (e.g., PAP Smear). The lab test is saved as a Women's Health procedure in the WV Procedure (#790.1) file. The user is placed in the procedure data entry screen and may edit/close out the procedure entry. The lab report can be viewed again by going into the Reports (WP) field.

The software may provide a default response at the "Select Lab Test Accession #:" prompt. The software checks each entry, if the user is the requesting provider for a test, or the Women's Health case manager for a patient, that entry will be displayed as a default response. A default response is provided until the user has looped through all associated tests or up-arrows out of the option. The user may enter a question mark to see a list of all entries or select any entry to process.

Note: This option can only work if the Lab package patch LR*5.2*231 is installed and the "Import Test from Laboratory" field is set to 'Yes' for the facility in the Edit Site Parameters [WV EDIT SITE PARAMETERS] option.

It is possible that the wrong patient was originally associated with a lab test. When this happens, the Lab package has an option to associate the correct patient with the lab test. The Lab package contains a check that will call the Women's Health package if a lab test is moved from one patient to another. If the lab test was converted into a Women's Health procedure entry the Women's Health package does the following:

1. Disassociates the Women's Health entry from the Lab package entry (i.e., will not delete the Women's Health entry, but will not show the lab results).
2. Changes the Result/Dx of the Women's Health entry to 'Error/disregard'.
3. Sends a mail message to the case manager stating lab results no longer belong to that patient and identify the Women's Health entry. The case manager can then make any additional changes or add notes to the record.
4. If the new patient associated with the lab test is female, then the lab test will be passed to the Women's Health package and stored as a new entry in the WV Lab Test (#790.08) file.

If the results of a lab test are ever edited by the Lab user, and the lab test was saved as a WH procedure entry, the case manager will receive a mail message indicating the lab report has changed. Also, the status of the WH procedure entry will be set to 'Open', and the Complete by (Date) is updated.

WV ADD A NEW PROCEDURE

Add a NEW Procedure

This option allows you to add procedures for patients. The first prompt asks you to select a patient (either by name, or SSN). The second prompt asks you to select a procedure. The possible choices of procedures are listed in the table below:

Breast Ultrasound - BU	LEEP - LP
Clinical Breast Exam - CB	Lumpectomy - LM
Colposcopy Impression (No BX) -CI	Mammogram Dx Bilat - MB
Colposcopy w/Biopsy - CO	Mammogram Dx Unilat - MU
Cone Biopsy - CN	Mammogram Screening - MS
Cryotherapy - CY	Mastectomy - MT
Ectocervical Biopsy - EB	Needle Biopsy - NB
Endocervical Curettage - EC	Open Biopsy - OB
Endometrial Biopsy - EM	PAP Smear - PS
Fine Needle Aspiration - FN	Pelvic Ultrasound - PU
General Surgery Consult - GS	Pregnancy Test - PT
GYN ONC Consult - GY	STD Evaluation - ST
Hysterectomy - HY	Stereotactic Biopsy - SB
Laser Ablation – LA	Tubal Ligation - TL
Laser Cone - LC	Vaginal Ultrasound - VU

The procedure is selected by typing either its name or its abbreviated code, for example, ‘PS’ will select ‘PAP Smear’. (These codes are also used in the accession numbers, for example, ‘PS1998-43’ will be an accession# for a PAP smear.)

If the procedure is a unilateral mammogram, an additional prompt will ask you to enter ‘Left or Right’. If the procedure is a colposcopy w/biopsy, an additional prompt will ask you to select the accession# of the PAP that initiated this colposcopy.

A final prompt asks you for the date of the procedure. At this point the computer checks to see if this procedure has already been entered for this patient on this date. If so, then this would be a duplicate procedure.

Once you have added a valid new procedure, the program will automatically assign the procedure a unique accession# and then proceed to the ‘Edit a Procedure’ screen. the accession# for a procedure uniquely identifies that procedure for all editing and reporting purposes. Procedure data is stored in the WV Procedure (#790.1) file.

NOTE: When a Radiology/Nuclear Medicine package exam is passed to the Women's Health package, an informational mail message is sent to the WH case manager.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Reports (WP):
If the report is from a Radiology/NM procedure, this field contains data from the Radiology/NM Report (#74) file. If a radiology report is unverified and then verified again, the words "AMENDED REPORT" will appear with the data displayed in this field. If the report is from a lab test, this field contains data from the Lab Data (#63) file. Users can get to this field by using the TAB key from the Ward/Clinic/Location field.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

Notes (WP):
A word-processing field for storing extensive notes/comments about this case. If there is text data present, a '+' will appear to the right of the field label, like so: (WP): +. Users can get to this field by using the TAB key from the Health Care Facility field.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Margins Clear:
This field indicates tissue sample showed no pathology at the margins of the tissue sample.

Ectocervical Biopsy:
This field contains the diagnosis or impression resulting from the cytology examination. Pointer to the WV Results/Diagnosis (#790.31) file.

Stage:
This field documents the clinical stage for invasive carcinoma of the cervix. If clinical stage is unknown, enter the summary ('S-') stage.

STD Evaluation:
This field documents the findings after testing for sexually transmitted diseases. Pointer to the WV Results/Diagnosis (#790.31) file.

WV EDIT PROCEDURE

Edit a Procedure

This option allows you to edit previously documented procedures for patients. The first prompt asks you to select an accession# or patient name. A patient's SSN may also be entered. An accession# would be of the form 'PS1998-24'. If you know the accession# of the procedure you wish to edit, it will be more efficient to select the procedure by its accession# rather than by its patient (some patients will have several procedures on file). Procedure data is stored in the WV Procedure (#790.1) file.

NOTE: When a Radiology/Nuclear Medicine package exam is passed to the Women's Health package, an informational mail message is sent to the WH case manager.

Field Descriptions:

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These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date of Procedure (Required):
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Clinician/Provider:
This field stores the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Reports (WP):
If the report is from a Radiology/NM procedure, this field contains data from the Radiology/NM Report (#74) file. If a radiology report is unverified and then verified again, the words "AMENDED REPORT" will appear with the data displayed in this field. If the report is from a lab test, this field contains data from the Lab Data (#63) file. Users can get to this field by using the TAB key from the Ward/Clinic/Location field.

Health Care Facility (Required):
This field identifies the name of the health care facility where this procedure was performed.

Notes (WP):
A word-processing field for storing extensive notes/comments about this case. If there is text data present, a '+' will appear to the right of the field label, like so: (WP): +. Users can get to this field by using the TAB key from the Health Care Facility field.

Comments:
An optional one-line clinical history note (limited to 78 characters).

Complete by (Date):
This field contains the date used to determine that this procedure record is delinquent when a close status has not been entered in the record.

Results/Diagnosis:
This field stores the main result or diagnosis of the patient's procedure. Pointer to the WV Results/Diagnosis (#790.31) file. The diagnosis or results for PAP smears are based on the Bethesda Classification system; those for mammograms use the American College of Radiology classification. Entries should not be locally edited. A list of the possible results/diagnosis for each procedure type is found in Appendix A.
NOTE: **Procedures cannot be deleted.** If a procedure has been entered in error or is invalid for some other reason, enter a results/diagnosis of 'Error/disregard'. Procedures with a results/diagnosis of 'Error/disregard' will not appear on Patient Profiles, nor will they be included in the various epidemiology reports. These procedures can be viewed only under the Patient Profile Including Errors option of the Manager's Patient Management menu.

HPV:
This field is used to document the presence or absence of the Human Papilloma Virus (HPV) in the cytology reports.

Sec Results/Diagnosis:
This field stores a secondary outcome/diagnosis associated with the procedure. Pointer to the WV Results/Diagnosis (#790.31) file.

Status:
This field contains the record's status (set of codes: O = Open, C = Closed, D = Delinquent) for the procedure. The value of this field is used in the Program Snapshot reports and the Browse Patients with Needs Past Due report.

WV PRINT A PROCEDURE

Print a Procedure

This option allows you to print information pertaining to a patient's procedure. You are prompted for an accession# or patient name, and for a device. The display/printout looks very similar to the 'Edit a Procedure' screen. Procedure data is stored in the WV Procedure (#790.1) file.

Report Description:

These fields appear on the top of every page of the report:

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

Procedure:
This field displays the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

Page 1:

Date of Procedure:
This field identifies the date on which the procedure was performed. Dates in the future may not be entered.

Date First Entered:
This field displays the date on which this procedure record was first entered.

First Entered By:
This field identifies the name of the person who first entered data on this procedure.

Lab Accession#:
This field displays the Laboratory package accession number for the procedure, if one exists.

Clinician/Provider:
This field displays the name of the clinician who ordered and/or performed this procedure.

Ward/Clinic/Location:
This field contains the name of the ward, clinic, or location where the procedure was performed. NOTE: If the entry in the Hospital Location (#44) file has the Institution (#3) field filled in, the institution will be provided as the default for the field Health Care Facility.

Health Care Facility:
This field identifies the name of the health care facility where this procedure was performed.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date Refused:
This field contains the date the patient refused the procedure, test or examination.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Reason:
This field indicates a general reason for why the patient refused treatment, i.e., (1) treatment was provided elsewhere, (2) no reason was given by the patient, or (3) another reason was provided by the patient.

Comments:
This field contains comments related to this refusal (limited to 3-75 characters).

WV REFUSED PROC-EDIT

Edit a Refusal of Treatment

This option allows editing of an existing patient's refusal for treatment. The user must identify the record to be edited by entering a date that the treatment was refused or by selecting from a list of records in the WV Refusals (#790.3) file. Refusal of treatment data is stored in the WV Refusals (#790.3) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Date Refused:
This field contains the date the patient refused the procedure, test or examination.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Reason:
This field indicates a general reason for why the patient refused treatment, i.e., (1) treatment was provided elsewhere, (2) no reason was given by the patient, or (3) another reason was provided by the patient.

Comments:
This field contains comments related to this refusal (limited to 3-75 characters).

WV ADD A NEW NOTIFICATION

Add a New Notification

This option allows you to add notifications for patients. A notification is a communication between the clinic staff and the patient.

When you add a notification, it must be given a type of notification. Most notifications are letters, however, they may also be phone calls, conversations, etc. The table below lists all of the types of notifications that are available in Women's Health:

CONTACT CHA	MESSAGE VIA PERSON
CONTACT PHN	MESSAGE VIA PHONE MACHINE
CONVERSATION WITH PATIENT	PHONE CALL, 1ST
LETTER, FIRST	PHONE CALL, 2ND
LETTER, SECOND	PHONE CALL, 3RD
LETTER, SECOND (CERTIFIED)	PROVIDER CONSULT
LETTER, THIRD (CERTIFIED)	

When you add a notification, it must also be given a purpose of notification. The purpose of notification is the reason the patient is being contacted. The table below lists the purposes of notification that come pre-loaded in Women's Health. It is possible to add other purposes of notification customized to your particular site, and to edit the ones listed below as well. (See Add/Edit a Notification Purpose & Letter option.)

COLP Abnormal, need further Tx
COLP follow up, PAP next month.
COLP follow up, next PAP 6 months.
DNKA Colposcopy (Did Not Keep Appt)
DNKA Colposcopy Follow Up
DNKA PAP routine
DNKA PAP asap
DNKA PAP urgent
MAM result normal, next MAM 1 year.
PAP abnormal, need colp 8-12 weeks PP.
PAP result abnl, rep PAP 3-6 mos.
PAP result abnormal, PAP 6 weeks P.P.
PAP result abnormal, next PAP 3 months and colp.
PAP result abnormal, schedule colposcopy.
PAP result normal, next PAP 1 year.
PAP result normal, next PAP 4 months.
PAP result normal, next PAP 6 months.

PAP, annual due.
PAP, follow-up due.
PREGNANCY Test NEGATIVE
PREGNANCY Test POSITIVE

Eventually, each notification should be given an outcome. The outcome of a notification describes the final result of the contact with the patient. The table below lists the outcomes that come pre-loaded in Women's Health. It is possible to add other outcomes customized to your particular site, and to edit the ones listed below as well. (See Add/Edit Notification Outcomes option.)

Chart Flagged
Declined Tx
MAM Normal letter sent
No known address
No response
PAP Normal letter sent
PHN referral
Patient Deceased
Patient left Service Area
Provider consult
Response not tracked
Scheduled appt for Colposcopy
Scheduled appt for PAP
Scheduled appt for Repeat PAP
Tx elsewhere
Unable to contact Patient

As stated above, this option allows you to add notifications for patients. The first prompt asks you to select a patient (either by name, or SSN). After you have selected a patient, the 'Edit a Notification' screen appears. Notification data is stored in the WV Notification (#790.4) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

WV EDIT NOTIFICATION

Edit a Notification

This option allows you to edit a notification that already exists. You are first asked to select a patient (by name or SSN), and then a notification (by date or accession#). Once you have selected a notification to edit, the 'Edit a Notification' screen will appear. You may select another notification to edit before returning to the menu. Notification data is stored in the WV Notification (#790.4) file.

Field Descriptions:

These fields appear above the dashed line on every screen. These fields are not editable through this option. They may be edited through Edit/Print Patient Case Data option (except patient name and SSN).

Patient Name:
This field contains the name of the patient associated with the procedure. Pointer to the WV Patient (#790) file.

SSN:
This field contains the social security number of the patient.

Case Manager:
This field contains the name of a WH case manager assigned to manage this women's health needs.

PAP Regimen:
This field contains the PAP regimen that was given to this patient at the date and time of this entry.

Cervical Treatment Need:
This field contains the name of the current or next gynecologic procedure or treatment need scheduled for this patient.

Cervical Treatment Facility:
This field contains the name of the facility responsible for providing the gynecological tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Breast Treatment Need:
This field contains the name of the current or next breast study procedure needed for this patient.

Breast Treatment Facility:
This field contains the name of the facility responsible for providing the breast study tests/exams for this patient. Facility choices are limited to entries in the Institution (#4) file.

Sexual Trauma:
This field indicates if the patient has experienced any sexual trauma (rape, sexual assault, etc.) either in the military and/or as a civilian. Set of codes: (M = Military, C = Civilian, B = Both, N = None).

Veteran:
This field contains a 'Yes' if the patient is a veteran, 'No' if the patient is not a veteran, or is blank if the veteran status of this patient is not known.

These fields appear below the dashed line:

Accession#:
This is the record number assigned by the Women's Health package. It is composed of the procedure's abbreviated code, a four digit year and a sequential number.

Procedure:
This field stores the name of the procedure performed on the patient. Pointer to the WV Procedure (#790.1) file.

Date Notification Opened (Required):
The date the notification was first created.

Facility (Required):
Select the health care facility with which this letter is associated. Each letter to be printed is associated with a specific facility. When a user runs the Print Queued Letters option, only letters associated with the user's facility will be printed. (The user's facility is the facility (also called 'Site' or 'Division') that the user selects at sign on. If a user has only one facility, that facility is assigned automatically. For more information about selecting facilities at sign on, contact your site manager.) This feature allows multiple clinics to manage patients and print letters on the same computer, using the same patient database, without printing one another's letters.

Purpose of Notification (Required):
This field contains the reason for the notification (e.g., the results of a test, reminder to schedule a procedure). This should be brief but descriptive enough to identify it uniquely. NOTE: This field cannot be changed because previous notifications from this purpose would become inaccurate. If the Purpose field is incorrect, make this purpose 'Inactive' (see next field), and then create a new purpose of notification with the correct purpose name.

WV PRINT SNAPSHOT

Snapshot of the Program Today

This option provides a calendar or fiscal year-to-date report that gives program statistics at a glance. This report also includes total counts of treatment refusals by procedure name. Before displaying the report, the program asks: 'Should today's Snapshot be stored for later retrieval and comparisons?' If you answer 'Yes', the results of the current date's snapshot will be stored after they have been printed out. These results can then be retrieved in the future (by selecting the date of the desired report) and compared to other snapshots in order to look at the trends and progress of your program over time. If you answer 'No', the program will simply print the current date's snapshot without storing it. NOTE: If a previous snapshot for the current date has been run, it will be overwritten by any later run on the same date.

The next question asks you to Select Device:. Enter 'Home' to have the report display on the screen. Snapshot data is stored in the WV Snapshot Reports (#790.71) file.

NOTE: A patient will not be processed if there is any value (past, present, or future) in the Date Inactive field.

Report Description:

Total Active Women in Register:
This field contains the total number of women with active records in the WV Patient (#790) file.

Women Who Are Pregnant:
This field contains the number of women who were pregnant at the time the program snapshot report option was run.

Women with Cervical Tx Needs not specified or not dated:
This field contains the number of women whose records indicated that their gynecologic treatment needs were not specified or the due date was not recorded. A woman will not be counted if her cervical treatment need value is "Not Indicated".

Women with Cervical Tx Needs specified and past due:
This field contains the number of women whose records indicated that their gynecologic treatment needs were specified and are past due.

Women with Breast Tx Needs not specified or not dated:
This field contains the number of women whose records indicated that their breast treatment needs were not specified or the due date was not recorded. A woman will not be counted if her breast treatment need value is "Not Indicated".

Women with Breast Tx Needs specified and past due:
This field contains the number of women whose records indicated that their breast treatment needs were specified and are past due.

Total Number of Procedures with a Status of 'OPEN':
This field contains the number of procedure records that have a status of 'Open'.

Number of OPEN Procedures Past Due (or not dated):
This field contains the number of procedure records (with an 'Open' status) which indicate that breast or gynecologic treatment needs are past due.

Total Number of PAP Smears done since Oct 1, 1997:
This field contains a count of the PAP smears done since the beginning of the calendar or fiscal year, depending upon what the user selected. NOTE: The date will either be Oct. 1 or Jan. 1 depending on whether the user chose fiscal or calendar year.

Total Number of CBEs done since Oct 1, 1997:
This field contains a count of the clinical breast exams (CBE) done since the beginning of the calendar or fiscal year, depending upon what the user selected. NOTE: The date will either be Oct. 1 or Jan. 1 depending on whether the user chose fiscal or calendar year.

Total Number of Mammograms done since Oct 1, 1997:
This field contains a count of the mammograms done since the beginning of the calendar or fiscal year, depending upon what the user selected. NOTE: The date will either be Oct. 1 or Jan. 1 depending on whether the user chose fiscal or calendar year.

Total Number of Notifications with a Status of 'OPEN':
This field displays the number of notification records, with a status of 'Open', when the program snapshot report was run.

Number of OPEN Notifications Past Due (or not dated):
This field contains the number of notification records that were past due when the program snapshot report was run.

Number of Letters Queued (for later printing):
This field contains the number of letters scheduled to be queued at a future time. This count is calculated from the Type of Notification and the Print Date fields in the WV Notification (#790.4) file.

REFUSALS for TREATMENT:

Breast Ultrasounds:
This field contains the number of records (in File #790.3) indicating that a patient declined having a breast ultrasound within the timeframe associated with the program snapshot report.

WV PRINT COMPLIANCE RATES

Compliance Rates for PAPs and MAMs

This report is designed to serve as an indicator of compliance rates for PAP smears (PAPs) and mammograms (MAMs), in other words, it indicates the percentage of women who are returning to the program on a regular basis (e.g., annually) for screenings. This report calculates the percentages based on the number of patients who are considered active in the Women's Health package for the date range selected. This report asks you for a date range, an age group, and a device.

This report can be run for a larger time frame, for example, 5 years, in order to obtain a broader sampling. If the report was run to cover a 5 year time frame, one would hope to see the highest percentages in the 5 column (assuming the goal is to have women return annually). The report can also be run several times for shorter time periods and the results compared, in order to examine trends.

This report serves only as an indicator (NOT as an exact count of compliance rates) for gauging the success rates of annual screening programs. It can be run for several different timeframes in order to examine trends. Assuming a screening cycle of one year, a minimum date range spanning 15 months is recommended. Compliance data is stored in the WV Patient (#790) file.

Report Description:

The report displays the percentages of women who received PAPs and MAMs for screening purposes only, within the selected date range, along with the number of active patients. The output will include a breakdown by current PAP regimen.

Only patients who have had normal results for procedures in the specified date range are counted; the intent is to exclude any procedures that would involve abnormal results, diagnostic and follow-up procedures, etc. Due to the complexities involved in the treatment of individual cases that involve abnormal results, those patients will not be included, even though some of them may have received screening PAPs or MAMs.

WV BROWSE NEEDS PAST DUE

Browse Patients With Needs Past Due

This option is exactly the same as is found under the Patient Management Menu.

Appendix A - Results/Diagnosis File by Procedure

```
          *  WOMEN'S HEALTH: LISTING OF RESULTS/DIAGNOSIS FILE  *PAGE 1
                          * BY PROCEDURE *
                       Run Date: OCT 04, 1999  15:21
-------------------------------------------------------------------------------
   PROCEDURE                       RESULT/DIAGNOSIS           PRIORITY  NORMAL
-------------------------------------------------------------------------------

   BREAST ULTRASOUND               Cystic Mass, Complicated          1  ABNORM
                                   Solid Mass, Irregular Margins     1  ABNORM
                                   Solid Mass, Smooth Margins        1  ABNORM
                                   Cystic Mass                       5  ABNORM
                                   No Discrete Mass                 90  NORMAL
                                   Error/disregard                  95  NO RES

   CLINICAL BREAST EXAM            Abnormal/other                    1  ABNORM
                                   Bloody Nipple Discharge           1  ABNORM
                                   Discrete Mass                     1  ABNORM
                                   Nipple/Areolar Scaliness          1  ABNORM
                                   Retraction/Dimpling               1  ABNORM
                                   Benign Findings                   6  NORMAL
                                   Not Available                    90  NO RES
                                   WNL/Normal                       90  NORMAL
                                   Error/disregard                  95  NO RES

   COLPOSCOPY IMPRESSION (NO BX)   Impression: Invasive CA           1  ABNORM
                                   Pregnant(no bx),Imp:Invasive      1  ABNORM
                                   Impression: CIN II                2  ABNORM
                                   Impression: CIN III               2  ABNORM
                                   Impression: VAIN II               2  ABNORM
                                   Impression: VAIN III              2  ABNORM
                                   Impression: VIN II                2  ABNORM
                                   Impression: VIN III               2  ABNORM
                                   Pregnant(no bx),Imp:CIN II        2  ABNORM
                                   Pregnant(no bx),Imp:CIN III       2  ABNORM
                                   Impression: CIN I                 3  ABNORM
                                   Impression: HPV                   3  ABNORM
                                   Impression: VAIN I                3  ABNORM
                                   Impression: VIN I                 3  ABNORM
                                   Pregnant(no bx),Imp:CIN I         3  ABNORM
                                   Pregnant(no bx),Imp:HPV           3  ABNORM
                                   Impression: Inflammation          5  ABNORM
                                   Pregnant(no bx),Imp:Inflam        6  NORMAL
                                   Impression: WNL/Normal           90  NORMAL
                                   Not Available                    90  NO RES
                                   Pregnant(no bx),Imp:WNL          90  NORMAL
                                   Error/disregard                  95  NO RES

   COLPOSCOPY W/BIOPSY             Insufficient Tissue               1  NO RES
                                   Invasive CA: Cervical             1  ABNORM
                                   Invasive CA: Other (non-cerv)     1  ABNORM
                                   CIN II/moderate dysplasia         2  ABNORM
                                   CIN III/severe dysplasia          2  ABNORM
                                   Unsatisfactory for Dx             2  NO RES
                                   VAIN II                           2  ABNORM
                                   VAIN III                          2  ABNORM
                                   VIN II                            2  ABNORM
                                   VIN III                           2  ABNORM
                                   CIN I/mild dysplasia              3  ABNORM
```

	HPV/condyloma	3	ABNORM
	VAIN I	3	ABNORM
	VIN I	3	ABNORM
	Inflammation/Cervicitis	5	ABNORM
	Benign Changes	6	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
CONE BIOPSY	Insufficient Tissue	1	NO RES
	Invasive CA: Cervical	1	ABNORM
	Invasive CA: Other (non-cerv)	1	ABNORM
	Other Malignant Neoplasms	1	ABNORM
	CIN II/moderate dysplasia	2	ABNORM
	CIN III/severe dysplasia	2	ABNORM
	Unsatisfactory for Dx	2	NO RES
	CIN I/mild dysplasia	3	ABNORM
	HPV/condyloma	3	ABNORM
	Inflammation/Cervicitis	5	ABNORM
	Benign Changes	6	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
CRYOTHERAPY	Done	92	NO RES
	Error/disregard	95	NO RES
ECTOCERVICAL BIOPSY	Insufficient Tissue	1	NO RES
	Invasive CA: Cervical	1	ABNORM
	Invasive CA: Other (non-cerv)	1	ABNORM
	CIN II/moderate dysplasia	2	ABNORM
	CIN III/severe dysplasia	2	ABNORM
	Unsatisfactory for Dx	2	NO RES
	CIN I/mild dysplasia	3	ABNORM
	HPV/condyloma	3	ABNORM
	Inflammation/Cervicitis	5	ABNORM
	Benign Changes	6	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
	Not Done	99	NO RES
ENDOCERVICAL CURRETTAGE	Insufficient Tissue	1	NO RES
	Invasive CA: Cervical	1	ABNORM
	Invasive CA: Other (non-cerv)	1	ABNORM
	CIN II/moderate dysplasia	2	ABNORM
	CIN III/severe dysplasia	2	ABNORM
	Unsatisfactory for Dx	2	NO RES
	CIN I/mild dysplasia	3	ABNORM
	HPV/condyloma	3	ABNORM
	Inflammation/Cervicitis	5	ABNORM
	Benign Changes	6	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
ENDOMETRIAL BIOPSY	Carcinoma, Non-invasive	1	ABNORM
	Insufficient Tissue	1	NO RES
	Invasive CA: Cervical	1	ABNORM
	Invasive CA: Other (non-cerv)	1	ABNORM
	Adenomatous Hyperplas w/Atypia	2	ABNORM
	Adenomatous Hyperplas w/o Atyp	3	ABNORM

	Endometritis	5	ABNORM
	Benign Changes	6	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
FINE NEEDLE ASPIRATION	Carcinoma-in-situ	1	ABNORM
	Carcinoma-in-situ, NED	1	ABNORM
	Carcinoma-in-situ, recurrent	1	ABNORM
	Insufficient Tissue	1	NO RES
	Invasive Ca	1	ABNORM
	Invasive Ca, NED	1	ABNORM
	Invasive Ca, progressive	1	ABNORM
	Invasive Ca, responding Rx	1	ABNORM
	Invasive Ca, stable	1	ABNORM
	Atypia	5	ABNORM
	Inflammation	5	ABNORM
	Benign Findings	6	NORMAL
	Error/disregard	95	NO RES
GENERAL SURGERY CONSULT	Carcinoma-in-situ	1	ABNORM
	Carcinoma-in-situ, NED	1	ABNORM
	Carcinoma-in-situ, recurrent	1	ABNORM
	Invasive Ca	1	ABNORM
	Invasive Ca, NED	1	ABNORM
	Invasive Ca, progressive	1	ABNORM
	Invasive Ca, responding Rx	1	ABNORM
	Invasive Ca, stable	1	ABNORM
	Atypia	5	ABNORM
	Inflammation	5	ABNORM
	Benign Findings	6	NORMAL
	Not Available	90	NO RES
	Error/disregard	95	NO RES
GYN ONC CONSULT	See Patient Chart/Record	10	NO RES
	Error/disregard	95	NO RES
HYSTERECTOMY	Adenoacanthoma	1	ABNORM
	Adenomyosis	1	ABNORM
	CA endometrium Stage I	1	ABNORM
	CA endometrium Stage II	1	ABNORM
	CA endometrium Stage III	1	ABNORM
	CA endometrium Stage IV	1	ABNORM
	Carcinoma-in-situ	1	ABNORM
	Cellular Leiomyoma	1	ABNORM
	Choriocarcinoma	1	ABNORM
	Chronic Pelvic Pain	1	ABNORM
	Congential abn of uterus NOS	1	ABNORM
	Cysto-urethrocele	1	ABNORM
	Cystocele	1	ABNORM
	Dysfunctional Uterine Bleeding	1	ABNORM
	Dysmenorrhea, intractable NOS	1	ABNORM
	Endometrial hyperplasia (rec)	1	ABNORM
	Endometriosis	1	ABNORM
	Enterocele	1	ABNORM
	Fibro Sarcoma	1	ABNORM
	Fibroids	1	ABNORM
	Generalized pelvic relaxation	1	ABNORM
	Hematometrium	1	ABNORM
	Hydatidiform mole	1	ABNORM
	Invasive CA: Cervical	1	ABNORM
	Invasive CA: Other (non-cerv)	1	ABNORM

	Other	1	ABNORM
	Other Malignant Neoplasms	1	ABNORM
	Ovarian CA NOS	1	ABNORM
	Placenta accreta	1	ABNORM
	Pregnancy - cornual	1	ABNORM
	Procidentia	1	ABNORM
	Prolapse grade II	1	ABNORM
	Prolapse grade III	1	ABNORM
	Pyosalpinx	1	ABNORM
	Rectocele	1	ABNORM
	Salpingitis isthmica nodosa	1	ABNORM
	Tubal CA NOS	1	ABNORM
	Tubo-ovarian abscess	1	ABNORM
	Uterine anomaly	1	ABNORM
	Uterine foreign body	1	ABNORM
	Uterine injury-external	1	ABNORM
	Uterine injury-surgical	1	ABNORM
	Uterine tuberculosis	1	ABNORM
	Adenomatous Hyperplas w/Atypia	2	ABNORM
	CIN II/moderate dysplasia	2	ABNORM
	CIN III/severe dysplasia	2	ABNORM
	CIN I/mild dysplasia	3	ABNORM
	Endometritis	5	ABNORM
	Inflammation/Cervicitis	5	ABNORM
	Error/disregard	95	NO RES
LASER ABLATION	Done	92	NO RES
	Error/disregard	95	NO RES
LASER CONE	Insufficient Tissue	1	NO RES
	Invasive CA: Cervical	1	ABNORM
	Invasive CA: Other (non-cerv)	1	ABNORM
	Other Malignant Neoplasms	1	ABNORM
	CIN II/moderate dysplasia	2	ABNORM
	CIN III/severe dysplasia	2	ABNORM
	Unsatisfactory for Dx	2	NO RES
	CIN I/mild dysplasia	3	ABNORM
	HPV/condyloma	3	ABNORM
	Inflammation/Cervicitis	5	ABNORM
	Benign Changes	6	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
LEEP	Insufficient Tissue	1	NO RES
	Invasive CA: Cervical	1	ABNORM
	Invasive CA: Other (non-cerv)	1	ABNORM
	Other Malignant Neoplasms	1	ABNORM
	CIN II/moderate dysplasia	2	ABNORM
	CIN III/severe dysplasia	2	ABNORM
	Unsatisfactory for Dx	2	NO RES
	CIN I/mild dysplasia	3	ABNORM
	HPV/condyloma	3	ABNORM
	Inflammation/Cervicitis	5	ABNORM
	Benign Changes	6	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
LUMPECTOMY	Carcinoma-in-situ	1	ABNORM
	Carcinoma-in-situ, NED	1	ABNORM
	Carcinoma-in-situ, recurrent	1	ABNORM

	Insufficient Tissue	1	NO RES
	Invasive Ca	1	ABNORM
	Invasive Ca, NED	1	ABNORM
	Invasive Ca, progressive	1	ABNORM
	Invasive Ca, responding Rx	1	ABNORM
	Invasive Ca, stable	1	ABNORM
	Atypia	5	ABNORM
	Inflammation	5	ABNORM
	Benign Findings	6	NORMAL
	Error/disregard	95	NO RES
MAMMOGRAM DX BILAT	Highly Sug of Malig, Tk Action	1	ABNORM
	Suspicious Abnorm, Consider Bx	1	ABNORM
	Assessment Is Incomplete	2	NO RES
	Unsatisfactory for Dx	2	NO RES
	Prbly Benign, Short Int F/U	4	ABNORM
	Benign Finding, Negative	5	NORMAL
	Indicated, But Not Performed	5	NO RES
	Not Indicated	50	NO RES
	Negative	90	NORMAL
	Error/disregard	95	NO RES
MAMMOGRAM DX UNILAT	Highly Sug of Malig, Tk Action	1	ABNORM
	Suspicious Abnorm, Consider Bx	1	ABNORM
	Assessment Is Incomplete	2	NO RES
	Unsatisfactory for Dx	2	NO RES
	Prbly Benign, Short Int F/U	4	ABNORM
	Benign Finding, Negative	5	NORMAL
	Indicated, But Not Performed	5	NO RES
	Not Indicated	50	NO RES
	Negative	90	NORMAL
	Error/disregard	95	NO RES
MAMMOGRAM SCREENING	Highly Sug of Malig, Tk Action	1	ABNORM
	Suspicious Abnorm, Consider Bx	1	ABNORM
	Assessment Is Incomplete	2	NO RES
	Unsatisfactory for Dx	2	NO RES
	Prbly Benign, Short Int F/U	4	ABNORM
	Benign Finding, Negative	5	NORMAL
	Indicated, But Not Performed	5	NO RES
	Not Indicated	50	NO RES
	Negative	90	NORMAL
	Error/disregard	95	NO RES
MASTECTOMY	Carcinoma-in-situ	1	ABNORM
	Carcinoma-in-situ, NED	1	ABNORM
	Carcinoma-in-situ, recurrent	1	ABNORM
	Insufficient Tissue	1	NO RES
	Invasive Ca	1	ABNORM
	Invasive Ca, NED	1	ABNORM
	Invasive Ca, progressive	1	ABNORM
	Invasive Ca, responding Rx	1	ABNORM
	Invasive Ca, stable	1	ABNORM
	Atypia	5	ABNORM
	Inflammation	5	ABNORM
	Benign Findings	6	NORMAL
	Error/disregard	95	NO RES
NEEDLE BIOPSY	Carcinoma-in-situ	1	ABNORM
	Carcinoma-in-situ, NED	1	ABNORM
	Carcinoma-in-situ, recurrent	1	ABNORM
	Insufficient Tissue	1	NO RES

	Invasive Ca	1	ABNORM
	Invasive Ca, NED	1	ABNORM
	Invasive Ca, progressive	1	ABNORM
	Invasive Ca, responding Rx	1	ABNORM
	Invasive Ca, stable	1	ABNORM
	Atypia	5	ABNORM
	Inflammation	5	ABNORM
	Benign Findings	6	NORMAL
	Error/disregard	95	NO RES
OPEN BIOPSY	Carcinoma-in-situ	1	ABNORM
	Carcinoma-in-situ, NED	1	ABNORM
	Carcinoma-in-situ, recurrent	1	ABNORM
	Insufficient Tissue	1	NO RES
	Invasive Ca	1	ABNORM
	Invasive Ca, NED	1	ABNORM
	Invasive Ca, progressive	1	ABNORM
	Invasive Ca, responding Rx	1	ABNORM
	Invasive Ca, stable	1	ABNORM
	Atypia	5	ABNORM
	Inflammation	5	ABNORM
	Benign Findings	6	NORMAL
	Error/disregard	95	NO RES
PAP SMEAR	AGCUS	1	ABNORM
	AGCUS, malignant	1	ABNORM
	AGCUS, premalignant	1	ABNORM
	ASCUS	1	ABNORM
	ASCUS, malignant	1	ABNORM
	ASCUS, premalignant	1	ABNORM
	Invasive CA: Cervical	1	ABNORM
	Other Malignant Neoplasms	1	ABNORM
	Squamous Cell Carcinoma	1	ABNORM
	Abnormal Appearing Cervix	2	ABNORM
	HGSIL: CIS/CINIII/CINII	2	ABNORM
	Unsatisfactory for Dx	2	NO RES
	LGSIL: CINI/HPV	3	ABNORM
	Benign Endometrial Cells	4	ABNORM
	Benign Cell Chgs: Infection	5	ABNORM
	Benign Cell Chgs: Other	5	NORMAL
	Benign Cell Chgs: react/IUD	5	NORMAL
	Benign Cell Chgs: react/atrphy	5	NORMAL
	Benign Cell Chgs: react/inflam	5	NORMAL
	Benign Cell Chgs: react/other	5	NORMAL
	Benign Cell Chgs: react/radiat	5	ABNORM
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
PELVIC ULTRASOUND	Done	92	NO RES
	Error/disregard	95	NO RES
PREGNANCY TEST	Positive	6	ABNORM
	Negative	90	NORMAL
	Error/disregard	95	NO RES
STD EVALUATION	2 or more STD’s	5	ABNORM
	3 or more STD’s	5	ABNORM
	Chlamydia	5	ABNORM
	Gonorrhea	5	ABNORM
	HIV	5	ABNORM
	Herpes	5	ABNORM

	Syphilis	5	ABNORM
	Trichomoniasis	5	ABNORM
	Positive	6	ABNORM
	Negative	90	NORMAL
	Not Available	90	NO RES
	WNL/Normal	90	NORMAL
	Error/disregard	95	NO RES
	Not Done	99	NO RES
STEREOTACTIC BIOPSY	Carcinoma-in-situ	1	ABNORM
	Carcinoma-in-situ, NED	1	ABNORM
	Carcinoma-in-situ, recurrent	1	ABNORM
	Insufficient Tissue	1	NO RES
	Invasive Ca	1	ABNORM
	Invasive Ca, NED	1	ABNORM
	Invasive Ca, progressive	1	ABNORM
	Invasive Ca, responding Rx	1	ABNORM
	Invasive Ca, stable	1	ABNORM
	Atypia	5	ABNORM
	Inflammation	5	ABNORM
	Benign Findings	6	NORMAL
	Error/disregard	95	NO RES
TUBAL LIGATION	Done	92	NO RES
	Error/disregard	95	NO RES
VAGINAL ULTRASOUND	Done	92	NO RES
	Error/disregard	95	NO RES